'Part of the problem, part of the solution' – adult physicians' role in adolescent and young adult health

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Since the birth of the NHS, it has been continuously reshaped to try and achieve its aim of 'good quality healthcare for all'. In hospitals, particular groups of patients, defined more by age and circumstance than condition, have been identified as requiring different approaches, for example, consider the ongoing focus on the older frail patients and those with dementia. This philosophy to care has led to dramatic improvements in quality and enhanced awareness and training.

Another group requiring that 'different approach' are adolescents and young adults. They have specific developmental needs, as well as health needs, which are recognised nationally[1,2] and internationally.[3] Young peoples' health stories are frequently in the media. Recently mental health, obesity, child sex exploitation and e-cigarettes have been highlighted. Positive interventions in this group has been described by the World Health Organization as a 'second chance in the second decade' and that 'chance' is to influence long-term health and other outcomes throughout adulthood.[3] However this heightened profile is yet to translate into action across many hospitals in the UK. Young people continue to remain almost invisible in our day-to-day working practice. To change this we need to define the problem.

Despite media reports and our own feelings of exasperation, young people are not the problem. Societal changes may have increased the problems that young people face. When the NHS was first created, young people started employment and got married, and had children much earlier than now. This protracted time between physical and sexual maturity and social and financial independence has been linked to issues related to mental health, behaviour and substance use.[4] Neuroscience has also provided some explanations as to why young people make the choices that they do in certain situations. Brain development has been shown to continue until the mid twenties, and that the area of the brain that controls emotion and reward becomes more efficient before the 'sensible area' that focuses on mentalising, planning, inhibition and future thinking.[5]

Adult services are, however, part of the problem. The way our services are designed has created a gap during the developmental phase of adolescence and young adulthood. Paediatric services are unable to fill the gap and adult services focus much of their attention on the growing number of older adults accessing care. Consequently, a young person as young as 16 can find themselves admitted for the first time to the adult ward, being placed in a bay with distressed confused older patients or attending clinic with a long-term condition seeing older patients with significant disabilities.

Lack of training is also part of the problem. The overriding feedback from over 600 future adult physicians is that they feel inadequately trained in managing adolescents;[6] similar surveys in paediatricians show the same.[7] At present, our training is condition focused and we specialise in an area or function of the body, although curricula may try to place this in the setting of a younger person, the trainee continues to see the condition first and not the young person.

Most worryingly, adult physicians and the services that they deliver are seen as part of the problem. This is particularly the case in the area of trying to achieve successful transition. Adult physicians may indeed have a different perspective, in a survey of adult gastroenterologists in the UK, 79% felt that inadequate preparation in paediatrics was part of the problem.[8] However, the blame for some young people suffering deterioration in health and getting lost to follow up following transfer is often laid firmly at our door.[9]

The benefit of being part of the problem is that we are also part of the solution. Since 2010, the Young Adult and Adolescent Steering Group at the Royal College of Physicians (RCP), with representatives from all specialist societies, have focused the RCP's efforts in improving the care of young people accessing adult services. The position statement published in 2014[10] states that the RCP is committed to 'high-quality, developmentally appropriate care, tailored to reflect the unique needs and preferences of individual patients during adolescence and young adulthood'.

Adult physicians need to see young people as first-time users of the health service. They may never have previously needed hospital care, or their parents navigated it for them. First impressions stick! The Kennedy report,[11] which reviewed services for children and young people in 2010, identified 'pockets of excellent practice' but these were described as 'islands in a sea of mediocrity'. The same is true of care of young people in adult services. The same 'excellent practice' can be found in adult services, particularly in relation to transition, and are highlighted in the imminent Future Hospital

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Programme (FHP) report. The challenge is to disseminate this practice.

Don't expect young people to do all the work in adapting to us; consider how we should adapt to them. Frequently all that may be required are 'tweaks', for example, rather than assuming that young people always choose not to attend clinics, look at strategies that can support young people in accessing care, whether that be improved communication around appointments, different timing of clinics or use of technologies. The benefits of getting it right for young people are likely to benefit your whole patient group. The *You're welcome* quality criteria from the Department of Health states the top eight criteria that need to be addressed to be able to call your service young person friendly.[12]

One of the eight criteria is 'staff training, skills, values and attitudes'. Adult physicians have many of these generic skills that could be honed for this age group, including direct involvement of the young person in decision making, important in encouraging independence; and also in health screening and promotion, vital to influence long-term outcomes in adulthood in young people with risk behaviours. In one study the most important determinant of a positive experience of transition was the 'patient centredness of the adult provider'.[13] What improved training looks like is not clear but work is ongoing to find some solutions.

Adult physicians need to recognise that young people accessing adult services, particularly acute care, are often the most vulnerable in society. The recent Public Health England document, *Improving young people's health and wellbeing*, urges a 'no wrong door' approach to working with young people.[2] Their need, or even choice, to present to acute services provides a unique opportunity to intervene, not only to reduce future admissions, but also to potentially change the trajectory that the young person is currently on. An RCP acute care toolkit to be launched this month aims to support physicians in acute services in achieving this vision. An example of such an opportunity could be in identifying and supporting young people at risk of child sexual exploitation (CSE). Guidance produced by the RCP[14] states: 'Physicians have a key role in identifying not only those young people who are being exploited, but also those at risk of exploitation'. The FHP offers real opportunities to change and improve services for patients, including young people. Many of the current development sites have had a focus on frail older patients, acute care or diabetes. With the work in the FHP focusing on transition providing the building blocks, hopefully future development sites will have the health of young people in their scope.

Although this is a call for adult physicians to be mindful about adolescents and young adults accessing their services, adult services should be supported by improved commissioning structures for the care of young people. The work of the national clinical director for children, young people and transition to adulthood through NHS England will hopefully change this by creating a structure to support continuity of care for young people undergoing transition at least.

The RCP has invested in its commitment to better adolescent and young adult care by recognising that young people are their responsibility, and this responsibility is beyond the concept of transition. The time has come for the NHS, and particularly adult services, to invest in the health of young people and by doing so, invest in the health of generations to come. ■

References

1 Viner R. Life stage. In: Department of Health, *Chief Medical Officer's annual report 2012: our children deserve better: prevention pays*. London: DoH, 2013.

2 Public Health England. *Improving young people's health and well-being: a framework for public health*. London: PHE, 2015. Available online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/399391/20150128_YP_HW_Framework_FINAL_WP__3_.pdf [Accessed 4 August 2015].

3 World Health Organization. *Health for the world's adolescents: a second chance in the second decade*. Geneva: WHO, 2014. Available online at www.who.int/maternal_child_adolescent/topics/adolescence/second-decade/en/ [Accessed 4 August 2015].

4 Patton GC, Viner R. Pubertal transitions in health. *Lancet* 2007;369:1130–9.

5 Steinberg L. A behavioral scientist looks at the science of adolescent brain development. *Brain Cogn* 2010;72:160–4.

6 Wright RJ, Howard EJ, Gleeson H. *The present state of higher specialist training in adolescent and young adult health in medical specialties in the UK*. Abstract presented at IAAH Lisbon, 2015.

7 Wright RJ, Gleeson HK. Training needs in adolescent and young adult health and transition in uk paediatric and adult higher specialist trainees in endocrinology and diabetes. *Br J Diabetes Vasc Dis* 2015, in press.

8 Sebastian S, Jenkins H, McCartney S *et al*. The requirements and barriers to successful transition of adolescents with inflammatory bowel disease: differing perceptions from a survey of adult and paediatric gastroenterologists. *J Crohns Colitis* 2012;6:830–44.

9 Gleeson H, McCartney S, Lidstone V. Everybody's business: transition and the role of adult physicians. *Clin Med* 2012;12:561–6.

10 Royal College of Physicians. *Position statement: Young adult and adolescent patient care*. 2014. London: RCP, 2014. Available online at www.rcplondon.ac.uk/update/rcp-position-statement-young-adult-and-adolescent-care [Accessed 4 August 2015].

11 Kennedy I. *Getting it right for children and young people: overcoming cultural barriers in the NHS so as to meet their needs*. London: DoH, 2010. Available online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/216282/dh_119446.pdf [Accessed 4 August 2015].

12 Department of Health. *Quality criteria for young people friendly health services*. London: DoH, 2011. Available online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf [Accessed 4 August 2015].

13 Van Staa A, Sattoe JNT. Young adults' experiences and satisfaction with the transfer of care. *J Adolesc Health* 2014;55:796–803.

14 Rogstad K, Wilkinson D, Forsyth S. Guidance for physicians on the detection of child sexual exploitation. London: RCP, 2015. Available online at www.rcplondon.ac.uk/sites/default/files/rcp_guidance_-_child_sexual_exploitation.pdf [Accessed 4 August 2015].

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